**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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|---|---|
| Requestor Name and Address:<br>SOUTH AUSTIN SURGERY CENTER<br>4207 JAMES CASEY SUITE 203<br>AUSTIN TX 78745 | MFDR Tracking #: M4-05-0311-01 |
| | DWC Claim #: |
| | Injured Employee: |
| Respondent Name and Box #:<br>LIBERTY MUTUAL FIRE INSURANCE<br>Box #: 01 | Date of Injury: |
| | Employer Name: |
| | Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "**Per TWCC Rule 134.401(a)(4):** Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements." "South Austin Surgery Center is an ambulatory surgery center (ASC) and regards 'fair and reasonable' rates of reimbursement as those paid on a consistent basis by a majority or payors. A majority of payors – including, but not limited to, Workers' Compensation carriers – consistently reimburse at the rate of 85% to 100% of our usual and customary fees for similar or identical services. Samples of similar or identical billings with explanation of benefits are provided and clearly support the contention that a 'fair and reasonable' rate of reimbursement is at least 85% of the amount billed. Despite our REQUEST FOR RECONSIDERATION by this carrier, this medical bill has not been reimbursed fairly or reasonably. Please review the supporting documentation and consider recommending additional reimbursement of the AMOUNT IN DISPUTE, which when combined with the TOTAL AMOUNT PAID (if applicable) is equal to 85% of AMOUNT BILLED."

**Amount in Dispute:** $30,236.12

## PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The bill was processed per Texas Fee Schedule @ fair & reasonable per LM ASC protocol as described previously in a multitude of other disputes. Our position remains the same."

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 2/12/2004 | Z601, Z652, X212, U849, X094, B377, U301, X801, X322 | Ambulatory Surgery Care Services | $30,236.12 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on September 7, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 14, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - Z601-The charge exceeds usual and customary.
   - Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
   - X212-This procedure is included in another procedure performed on this date.

- U849-This multiple procedure was reduced 50% according to fee schedule or usual and customary guidelines.
- X094-Charges included in the facility fee.
- B377-This is a bundled procedure; no separate payment allowed.
- U301, X801-This item was previously submitted and reviewed with notification of decision issued to payor/provider (Duplicate Invoice).
- X322, N-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.

2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
3. Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements."
4. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(g)(3)(E), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to "Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party in the dispute must be redacted by the party submitting the documentation, to protect the confidential information and the privacy of the individual. Un-redacted information or evidence shall not be considered in resolving the medical fee dispute." Review of the documentation submitted by the requestor finds that the requestor has submitted unredacted confidential information regarding a person other than the injured employee. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(g)(3)(E).
7. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
8. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states "South Austin Surgery Center is an ambulatory surgery center (ASC) and regards 'fair and reasonable' rates of reimbursement as those paid on a consistent basis by a majority or payors. A majority of payors – including, but not limited to, Workers' Compensation carriers – consistently reimburse at the rate of 85% to 100% of our usual and customary fees for similar or identical services. Samples of similar or identical billings with explanation of benefits are provided and clearly support the contention that a 'fair and reasonable' rate of reimbursement is at least 85% of the amount billed. Despite our REQUEST FOR RECONSIDERATION by this carrier, this medical bill has not been reimbursed fairly or reasonably. Please review the supporting documentation and consider recommending additional reimbursement of the AMOUNT IN DISPUTE, which when combined with the TOTAL AMOUNT PAID (if applicable) is equal to 85% of AMOUNT BILLED."
   - The requestor does not discuss or explain how payment of 85% of charges would result in a fair and reasonable reimbursement.
   - The requestor did not discuss or explain how it determined that 85% of the amount billed would yield a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that most carriers reimburse 85% of the amount billed.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.

- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(E), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

**DECISION:**

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|---|---|---|
| | | **4/20/2011** |
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |
| | | **4/20/2011** |
| Authorized Signature | Health Care Business Management Director | Date |

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**